



PA17-2007: QUALAQUIN REQUEST

RI MEDICAL ASSISTANCE PROGRAM PRIOR AUTHORIZATION REQUEST FORM

FAX TO:
DEPARTMENT OF HUMAN SERVICES
ATTN: PHARMACIST
401-462-6336

NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

CLIENT NAME _____ DOB: __/__/____ MEDICAID ID CARD NUMBER: / / / / / / / / /

PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER () ____ - _____

REQUESTER NAME: _____ RN /MD /R.PH / _____

PHONE NUMBER () ____ - _____ FAX NUMBER () ____ - _____

DRUG REQUESTED _____ STRENGTH _____

REQUEST TYPE (CIRCLE ONE) INITIAL / REAUTHORIZATION START DATE _____ UNITS / RX _____

DURATION OF THERAPY: 1 3 6 9 12 MONTHS (CIRCLE ONE) DOSING FREQUENCY: _____

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS
www.dhs.state.ri.us/dhs/heacre/provsvcs/mpharpa.htm

Does the patient have a diagnosis of malaria? Yes/No

COMMENTS:

PREScriBER SIGNATURE _____ DATE _____

By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

PA # _____ APPROVED _____

DENIED _____

PENDING ADDITIONAL INFORMATION _____

DATE /TIME OF RECEIPT _____

DATE/TIME RESPONSE _____

REVIEWER _____

COMMENTS:

**DHS RI PRIOR AUTHORIZATION
FAX NUMBER 401-462-6336**

**CONTACT EDS CUSTOMER SERVICE FOR QUESTIONS:
401-784-8100**